

Society Reports.

THE NEW YORK NEUROLOGICAL SOCIETY.

*Stated Meeting, held at the New York Academy of Medicine,
on Tuesday Evening, March 5, 1895.*

Dr. EDWARD D. FISHER, President, in the chair.

CHARCOT MONUMENT FUND.

DR. C. A. HERTER, the chairman of the Charcot Monument Fund Committee, reported that \$640 had been received up to the present time.

Dr. ALFRED WIENER exhibited the brain removed from a boy aged fourteen years, who, eight weeks ago, had an attack of acute articular rheumatism. From this he recovered entirely, and was able to return to school. Eight days ago he began to complain of pain in the right occipital and frontal region and some pain in the right ear. The pain over the frontal region gradually grew more severe and afterwards became more pronounced on the left side. There were no eye symptoms at any time, and no discharge from the ears. A diagnosis of meningitis was made. The patient was seen in consultation by Drs. Sachs and Gruening, who confirmed the diagnosis, but the latter suspected a thrombus in the lateral sinus. The temperature became more and more elevated, and pyæmic in character towards the last, and the boy died in a stuporous condition on the seventh day. At the autopsy, made twenty-four hours after death, a necrosis of the posterior surface of the petrous portion of the right temporal bone was found, with an acute meningitis on the opposite side of the brain. There was also a small thrombus of the lateral sinus, and the tentorium cerebelli was infiltrated with pus. The boy's mother stated that four months ago he had a suppurating otitis,

which seemed to have healed entirely, for up to four weeks before he was taken sick the ear had ceased to discharge and the perforation had closed. The advisability of an operation was carefully considered, but as there were not present enough symptoms to localize the lesion, and, therefore, warrant any such procedure, the idea of surgical interference was given up.

Dr. PHILIP MEIROWITZ exhibited a number of mounted cross-sections of the medulla, pons and corpora quadrigemina. The sections were taken from the normal subject and stained by Weigert's method, as modified by Pal and Vassale.

Dr. LOUIS F. BISHOP presented a case of œdema of the right upper extremity. The patient was a female, aged thirty-nine; married; no hereditary disease; eight brothers and sisters living; no previous serious illness; no cardiac, renal, or rheumatic history; has had seven children—five miscarriages; last child one year ago; no hysterical or other nervous symptoms; general health, excellent. Seven months ago, without any apparent cause, she noticed a swelling of the thumb of the right hand. Two months later she noticed swelling of the back of the hand. Quite lately the swelling has extended to the elbow. The swelling is worse at menstrual periods, and recently disappeared temporarily when in bed for a few days during an attack of influenza.

Physical examination: Heart sounds normal; lungs negative; right hand, œdematous; capillary circulation, more sluggish than on opposite side; pulse same as opposite side; no loss of power.

Examination of axilla, negative; no pain at any time. Dr. Bishop said he regarded the case as one of angioneurotic-œdema.

Dr. JOSEPH COLLINS said that Dr. Bishop's case, in most of its characteristics, did not agree with the symptoms that have been usually observed in these cases. Angioneurotic-œdema is evanescent, the swelling rarely lasting more than a few days, and does not pit on pressure. In this case there is slight pitting on pressure and an absence of the tense, hard skin usually seen.

Dr. C. L. DANA said that while this case did not correspond with the ordinary picture of this affection, yet there are cases of neurotic œdema which affect the limb in this way. All other possible causes of the œdema must be carefully excluded.

Dr. WILLIAM M. LESZYNSKY presented a woman who had an opening in the skull, in the left parietal region. The opening did not extend through the inner table. It was irregular in outline, with fissures running in different directions. There was no history of trauma, and the condition had existed from early childhood. Six years ago the patient began to suffer from epilepsy, the attacks being general in character. Dr. Leszynsky expressed the opinion that the loss of bone might be the result of a trauma in early life, followed by periostitis, or possibly the result of a syphilitic periostitis.

Dr. DANA said the deficiency in the cranium in this case was probably the result of a defect in osseous development, and he regarded it as one of the stigmata of degeneration which sometime accompany epilepsy.

Dr. L. STIEGLITZ exhibited a pathological specimen in connection with the report of the following case: The patient was a female, aged twenty months. She was first seen in November, 1894, when she presented the clinical picture of complete left hemiplegia, and paralysis of the right third nerve. The child was poorly developed. The left knee-jerk was exaggerated. Both pain and temperature sense were unaffected on the paralyzed side. The mother stated that six months before, she had noticed that the child did not use its left arm as freely as the right. The paralysis from that time on gradually increased, until the child gave up all attempts at walking. Three months before coming under observation the ptosis of the right eye came on, with divergent squint. A diagnosis of tumor, probably tubercular, in the right crus was made, although the possibility of glioma was considered. The following December paralysis of the left third nerve developed, indicating involvement of the left crus, and the child grew drowsy and apathetic. On February 17, 1895, there were twitchings, epileptic in character, on the paralyzed side of the body. Death occurred two days later. At the autopsy, which was made two hours after death, the brain was found to be large; the lateral ventricles dilated. In the right crus a tumor was found, with a cheesy centre. This spread upwards and forwards across the median lines into the left crus, involving the region of the nucleus of the third nerve.

Dr. B. SACHS referred to a similar case which he published in the *American Journal of Medical Science* some years ago.

The president, Dr. FISHER, said that the epileptic seizures in this case were of interest, as the tumor was so far from the cortex. They could only be explained on the ground that the impulses from the cortex were interrupted as they passed downwards to the cord.

A CASE OF TABES, ASSOCIATED WITH POST-HEMIPLEGIC ATHETOSIS AND UNILATERAL REFLEX IRIDOPLEGIA (See page 294).

DISCUSSION.

Dr. SACHS said he was inclined to regard the case as one of cerebro-spinal syphilis of the tabic type. He would insist on that diagnosis even if no history of syphilitic infection was obtainable. One very important symptom which points in that direction is the dissimilarity of the ocular conditions on the two sides. The movements of the right hand, Dr. Sachs said, he hardly regarded as an athetosis; to call them ataxic or choreic he thought would be more correct. They were probably due to an irritating lesion of the capsule or the ganglia surrounding it. As regards the movements of the eyes, the speaker said that these lateral jerky movements which are frequently styled nystagmus are not to be compared with the rapid occillary movements we get in true nystagmus. He has noticed slight movements of this character in persons with tabes and in entirely healthy subjects.

Dr. HERTER said he still held to his original view that the case was probably one of multiple sclerosis. He did this chiefly because he believes that a certain proportion of cases of multiple sclerosis are of syphilitic origin. Notwithstanding the fact that it has been pretty clearly shown that this man has had syphilis, his symptoms correspond more closely to multiple sclerosis than to tabes. The man has probably had cerebro-spinal syphilis, and at the present time he has that sclerotic process going on which belongs to the later period of the disease. The changes that have occurred in his brain and cord are probably of a sclerotic, rather than of an inflammatory nature. Recent researches show that in multiple sclerosis the patches of degeneration scattered in an irregular way throughout the nervous system, are clearly related to the blood-vessels. Very often a blood-

vessel is seen in the centre of a patch and compound granular capsules and other evidences of subsiding inflammation are seen in the periphery of patches of undoubted multiple sclerosis.

Dr. HERTER said that in reaching a diagnosis in this case, he laid considerable stress on the nystagmus, which he believes is more commonly met with in multiple sclerosis than in tabes. This patient also has marked slowness and slurring of speech. There is an entire absence of ataxia in the legs, and he has never had any lightning like pains. The pupils are not the typical Argyll-Robertson pupils, and are more in line with those found in multiple cerebro-spinal syphilis than with those of tabes. It was stated at the last meeting that the man was impotent for a time: on questioning him about this he stated that there was a loss of sexual desire, but he was always able to have erections. The slight optic atrophy which exists is quite as characteristic of multiple sclerosis as of tabes.

Dr. J. ARTHUR BOOTH said that during his examination of the man, made a few days ago, forced flexion and extension of the ear produced a distinct occillatory tumor, which he regarded as a symptom of sclerosis. The man's penis bears a scar which he claims was produced by bringing it in contact with a hot stove.

Dr. FREDERICK PETERSON said that he was not prepared to uphold his diagnosis of multiple sclerosis in this case so positively, after hearing the thoughts and additions in the history as given in the latest accounts by Dr. Collins. The exhibition of the case had shown it at first as one of tabes with athetosis, supposing probably that the whole condition was one process. I am glad to note that he now believes with the rest of us that the condition is one of multiple lesions at any rate. Now the only symptom in the case which is particularly significant of tabes is the absent knee-jerks, which may be with him a physiological condition, or may be due to multiple sclerosis affecting the posterior columns.

The man has had no pain. He has no ataxia. He has no sphincter trouble. His pupils react to light, and the ciliospinal reflex is present on both sides, as I examined this latter reflex very carefully with the faradic current to determine that point. There never was any impotence in this case, according to the testimony of the patient, though Dr. Collins makes an important symptom out of a suppose impotence. On the other hand, we

have symptoms not at all related to tabes; such as a species of nystagmus, which, while not so typical a movement as we sometimes find in sclerosis, is still so marked that we may positively state that it is not the mere twitching of a neurasthenic condition, but a species of nystagmus due to organic disorder. There being no history of syphilis, it is difficult to concede the case to be one of general cerebro-spinal syphilis, a term which may be made to cover almost any obscure pathological condition in the central nervous system. The patient has multiple lesions, and the chief fact at issue can be positively stated to be that the case is absolutely not one of locomotor ataxia with athetosis, and that there is probably no tabes about the case at all, as he presents only one symptom of that condition.

Dr. G. M. HAMMOND said he also had examined the patient, and was ready to agree with all the speakers. He agreed with the statement that the man had post-hemiplegic athetosis; with Dr. Sachs' opinion that he had cerebro spinal syphilis, and with Dr. Herter that the lesions are multiple and probably sclerotic in character. The patient evidently had two distinct affections. He had had a cerebral hæmorrhage about fifteen years ago. The peculiar atheto-choreiform movements were the result of this lesion. Dr. Hammond did not agree with Dr. Collins in regard to the situation of the lesion. The fact that the patient had a post-hemiplegic mobile spasm indicated, in his opinion, that the initial lesion invaded either the striatum or the thalamus.

The second affection from which the patient suffered began about a year ago. It is an ataxia which differed but little in its details from the typical cases of that disease.

Dr. FISHER made a diagnosis of cerebro-spinal syphilis. He saw nothing which would indicate multiple sclerosis.

Dr. COLLINS, in closing the discussion, said he did not see how this could be regarded as a case of multiple sclerosis, unless our present conception of that disease be utterly changed. It is unnecessary to rehearse the different symptoms on which the diagnosis was based.

In reply to Dr. Peterson's remark that there never had been a period of impotency, Dr. Collins did not think it necessary to dwell upon this, for if the testimony of the patient and his wife is to be allowed, then impotency was present as stated. What Dr. Peterson meant by saying

that the chief fact at issue can be positively stated to be that the speaker was unable to grasp, as there is no fact at issue, and most of the gentlemen believed that the clinical picture was one of locomotor ataxia and athetosis. Unquestionably the man has multiple lesions, otherwise he could not have three distinct sets of symptoms; but multiple lesions do not by any means imply multiple sclerosis, for the latter is a clinical entity, having a well-defined symptom complex, and unless we are willing to depart from all previous ideas of multiple sclerosis this case can not be considered as in any way related to it.

PALMUS.

Dr. LANDON CARTER GRAY read a paper with this title. He stated that within the last few years he has seen a number of patients with certain muscular movements to which the French authors have given the name "*tic convulsif*." They were first described in 1885 by Gilles de la Tourette, under the name, "A Nervous Affection Characterized by Motor Inco-ordination, Accompanied by Echolalia and Coprolalia." The details of this description are as follows: Motor inco-ordination is the first symptom, beginning gradually, and without apparently influencing the general health. The face or the upper extremities are first affected. It is first noticed that the fingers are alternately extended and flexed, or that the shoulders are raised. At about the same time the muscles of the face become implicated; there is often incessant winking, or the buccal commissures are actively drawn upwards and outwards, or there is contraction of the masseters, causing a grating of the teeth, or there may be projection of the tongue. The muscles of the neck may take part in the movements, the head being alternately flexed and extended. The lower extremities may share in the general disturbance, but the inco-ordination in them is somewhat different, in that the movements are not limited to isolated muscular groups, as is the case in the parts above described, but extend over the entirety of the muscles of one or the other member, and sometimes over both. The patient stamps his foot, stoops, or erects himself, or the movement may consist of a veritable jump. All these movements are very sudden and rapid, and may be accompanied by an inarticulate cry. At times this cry may be articulate, consisting of a word which varies in different

patients, and which was supposed to possess certain characteristics of an echo; hence the name echolalia. The coprolalia was regarded by La Tourette as pathognomonic, and consists of profane oaths or obscene epithets. The French authors had their attention directed to this subject by the descriptions of two American writers—those of Beard upon the Jumpers of Maine, published in 1880, and that of Hammond upon Miryachit, a similar disease of the Orient.

Dr. Gray said that the main symptoms of this affection are much more frequent than has been hitherto supposed, and he has ventured to coin for it a new name, that of *Palmus*, from the Greek word, *palmus*, meaning palpitation or twitching of the heart. The affection is divisible into the following types:

1. *Facial Palmus*. This constitutes the most frequent type. It consists of sudden, shock-like movements of lightning-like rapidity, causing a sudden wink or twitch of one cheek, occasionally of both, or of the brow. This series of movements is generally followed by a second series, weaker than the first, and sometimes by a third. In the majority of cases the winking is bilateral.

2. *General Palmus*. These consist of intermittent, shock-like movements of different muscles of the body.

3. *Acute Palmus*. In one case of this, coming under his observation the patient was a boy aged six years. He had then had the trouble about six months. His palmodic movements were very curious. For instance, when standing near a table looking at something, his chin would suddenly come down with a thump that would leave a black and blue mark; or, while standing quietly, his legs would give a sudden twitch, and he would be thrown violently to the ground.

4. *General Palmus, with Pseudo-melancholia*. Of this type two cases have come under his observation.

The diagnosis of *palmus* can be readily made. The only disease with which it is likely to be confounded is chorea, from which it differs radically. In chorea the movements usually involve the *fabrillæ* of muscles, and not muscular groups, either acting singly or in co-ordination with other muscular groups.

The prognosis varies according to the type. The author stated he has never yet seen a case of the facial or general variety cured; however, in none of those cases was he able to carry out prolonged and rigid treatment. The case of acute *palmus* was readily cured

under large doses of arsenic and rest in bed. One case of palmus with pseudo-melancholia was cured; the other was lost sight of.

Thus far no light has been thrown upon the pathology of this disease. As regards treatment, arsenic has a beneficial effect, but this is not of as long duration as the same drug has in chorea. In the facial and general varieties the arsenic alone will not answer, and in one case of generalized palmus with pseudo-melancholia it had no effect whatever. Hyoscyamine and hyoscine have a good effect in some cases. Iron has been utterly useless; also the bromides. Galvanic electricity is of distinct benefit. In facial palmus he has seen good results from the removal of errors of refraction or irritative lesions of the naso-pharynx. Absolute rest is also indicated, particularly at the outset, and the general health of the patient should receive attention.

Dr. DAVID WEBSTER said that palmus appears to be an affection which is known under various names. About twenty-five years ago he first became acquainted with it under the name of blepharospasm. Later on it was called blepharo-facial spasm; and, still later, hemi- or bi-facial spasm, the latter when both sides of the face were affected. Then, again, it was heard of under the name of *tic convulsif*, and finally palmus. There are several varieties of the disease. The easiest kind of all to cure is that which only simulates the real disease, and is produced by a local irritation, such as foreign bodies in the eye, etc. Another variety is most common in school children, who are perhaps poorly nourished and use their eyes too much; sometimes a number of cases occur in the same school, which is probably due to imitation. These cases are generally curable. One such case under his observation was cured by the local use of atropine and proper glasses. In another case the symptoms disappeared after a congenital phimosis had been removed. A very severe and intractable variety of the disease is sometimes met with in the aged. Internally, he usually employs arsenic in the treatment of these cases. Conium has also been recommended.

Dr. G. M. HAMMOND said that about eight years ago he read a paper on this subject in which he reported a number of cases. In his experience, arsenic, even in toxic doses, rarely proves of much benefit. On the other hand, he has used conium with much success. He usually

begins with five-drop doses, which are gradually increased to twenty-five or thirty drops.

Dr. T. R. POOLEY said that two varieties of blepharospasm are usually recognized; the symptomatic, which depends on some eye lesion, the presence of a foreign body, etc., and the essential blepharospasm, which is entirely independent of such cause. In the first variety, if we cure the eye trouble we cure the blepharospasm. In both varieties the symptoms may manifest themselves in either the clonic or tonic form; in the former, the movements of the lids are momentary, while in the latter form, the lids may remain closed for a considerable period of time. In nearly all of these cases, pressure points may be found, generally in relation with the trigeminal nerve or some of its branches. The supra- and infra-orbital branches are often favorite locations. Such pressure points may also be found in the nose, throat and mouth, especially when carious teeth exist. In exceptional cases they are found in other and more remote parts of the body. When such a pressure is pressed upon, the movements cease like magic. The way to cure the disease is to attack the point from which the reflex irritation starts. Stretching of the nerve is recommended in severe cases.

Dr. GRAY then closed the discussion.